DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/28/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185120	A. BUILDING _____ B. WING _____	C 10/19/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST HEALTH CARE CENTER	3740 OLD HARTFORD RD OWENSBORO, KY 42303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Abbreviated surveys (KY #16379, KY #15448 & KY #15449) were conducted on 10/14/10 through 10/19/10. KY #15379 and KY #15449 were unsubstantiated with no deficiencies cited. KY #15448 was substantiated with a deficiency cited at F 333 at a S/S of "D".	F 000	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on interviews and record review, it was determined the facility failed to ensure, one resident (#1) in the selected sample of 10, was free of any significant medication errors. Resident #1 received the medications (Coreg, Furosemide and Glucophage) for six days after they had been discontinued. Findings include: A review of the facility's Admission of the Resident policy and procedure, dated 04/28/09, revealed the nurse should notify, obtain and validate the admission orders to include medication orders. A record review revealed Resident #1 was admitted to the facility, on 09/21/10, with diagnoses to include Recent Myocardial Infarction and Right Cerebral Infarction with left sided Paralysis. A review of Resident #1's hospital Physician Medication Discharge Summary, dated 09/21/10, revealed a sheet labeled Home Medications Not	F 333	On September 27, 2010 the Nurse Practitioner (NP) reviewed resident # 1 hospital discharge summary and noted the resident was receiving Coreg 12.5mg two times daily, Torsemide 20 mg at bedtime, and Glucophage 500 mg two times daily. The NP further investigated and found these 3 medications were medications that resident #1 had previously been receiving at home but had not been receiving during recent hospitalization. After conferring with the attending physician, the NP gave an order to discontinue the Coreg, Torsemide, and Glucophage. On 10/15/10 an audit for accuracy of admission orders was conducted by the Director of Nursing, Nurse Practitioner, Assistant Director of Nursing, Licensed Nurse Unit Managers, the RN Case Manager, and the licensed nurse Medical Records Manager. The audit included current active residents that were admitted in the past 60 days from the date of the audit. No discrepancy of orders was noted in the audit.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Nancy Russell — TITLE: Exec Director — (X6) DATE: 11-1-10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

PRINTED: 10/20/2010
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185120	A. BUILDING _____ B. WING _____	C 10/19/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST HEALTH CARE CENTER	3740 OLD HARTFORD RD OWENSBORO, KY 42303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 333	Continued From page 1 Currently Receiving which listed Coreg (a beta-blocker, anti-hypertensive)12.5 mg. by mouth two times a day, Furosemide (diuretic) 20 mg. by mouth at bedtime and Glucophage (anti-diabetic) 500 mg. by mouth two times a day. The sheet had not been checked to indicate the medications should be continued or stopped. A review of Resident #1's Admission Orders Record, dated 09/21/10 through 10/21/10, revealed the nurse wrote the Coreg, Furosemide and Glucophage on the Admission Orders. A review of the September 2010 Medication Administration Record, revealed Resident #1 received the Coreg, Glucophage and Furosemide from 09/22/10 through the morning dose of 09/27/10 (a total of 6 days), which should have been discontinued on 09/21/10. The orders were not discontinued until 09/27/10. A review of the physician progress note, dated 09/27/10, revealed the resident became weak in therapy. The resident's blood pressure was low at 80/40. A review of a physician's order, dated 09/27/10, revealed the Nurse Practitioner (NP) discontinued the Coreg, Furosemide and Glucophage, ordered the resident's blood pressure taken every two hours until bedtime, to encourage the resident to drink fluids throughout the night and to call if there were any changes. An interview with Licensed Practical Nurse (LPN) #1, on 10/14/10 at 11:20 AM, revealed she made a mistake when she was taking off the orders. She stated she was confused because she had received several copies of the orders. She stated the resident should not have received those medications. LPN #1 revealed when she called to verify the orders with the physician, she told	F 333	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* Licensed nurses were in-serviced by the Staff Development Coordinator to read each order to the physician or nurse practitioner when verifying orders via telephone. Admission orders are to be reviewed by a second licensed nurse after the admitting nurse has transcribed the admission orders. Both nurses are to sign off on the admission orders to note that the orders were transcribed correctly. On the first business day following an admission, the unit manager and medical records personnel will review the admission orders to validate accuracy of the admission orders. Medication/treatment error reports will be filed for any noted errors. The Director of nursing will be notified of any medication/treatment errors. The Director of nursing will provide a summary report of any medication/treatment errors to the Performance Improvement Committee for review monthly.	Completion Date 11-1-10

PRINTED: 10/28/2010
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185120	A. BUILDING _____ B. WING _____	C 10/19/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST HEALTH CARE CENTER	3740 OLD HARTFORD RD OWENSBORO, KY 42303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 333	Continued From page 2 him she had received the discharge orders but did not actually read each medication to the physician. An interview with the NP, on 10/14/10 at 9:45 AM, revealed when Resident #1's blood pressure dropped, she reviewed the resident's medication orders and identified that Coreg, Glucophage and Furosemide should have been discontinued but was still being administered. She consulted with the physician and immediately discontinued the medications and gave an order for staff to monitor the resident's blood pressure every two hours and to encourage the resident to drink fluids. She stated she had talked to the physician and the physician did not think receiving the three medications had caused the resident's blood pressure to drop. She stated the physician stated the resident's blood pressure had dropped when he/she was in the hospital. Additionally, the NP stated the resident did not want to go to the hospital.	F 333		